NEW MEXICO
Department of Health
Developmental Disabilities Supports Division

MICHELLE LUJAN GRISHAM
Governor

DR. TRACIE C. COLLINS, M.D.
Cabinet Secretary

Date:	April 15, 2021
To:	Michelle Harmon, Clinical Services Director
Provider: Address: State/Zip:	ARCA 11300 Lomas Blvd. NE Albuquerque, New Mexico 87112-5512
E-mail Address:	mharmon@arcaspirit.org
Region: Survey Date:	Metro March 8 – 19, 2021
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Family Living, Intensive Medical Living, Customized In-Home Supports, Customized Community Supports, and Community Integrated Employment Services
Survey Type:	Routine
Team Leader:	Kayla R. Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Elisa Alford, MSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Bernadette Baca, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Joshua Burghart, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Beverly Estrada, ADN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Verna Newman-Sikes, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Caitlin Wall, BA, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Wolf Krusemark, BFA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau

Dear Michelle Harmon;

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Determination of Compliance:
The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags: This determination is based on noncompliance with one to five (1 – 5) Condition of Participation Level Tags *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 1A09 Medication Delivery Routine Medication Administration
- Tag # 1A09.1 Medication Delivery PRN Medication Administration
- Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication
- Tag # 1A15.2 Administration Case File: Healthcare Documentation (Therap and Required Plans)
- Tag # 1A31 Client Rights/Human Rights

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File (Other Required Documents)
- Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components
- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry
- Tag # 1A43.1 General Events reporting: Individual Reporting
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A09.0 Medication Delivery Routine Medication Administration
- Tag # 1A09.1.0 Medication Delivery PRN Medication Administration
- Tag # LS06 Family Living Requirements
- Tag # LS25 Residential Health & Safety (Supported Living & Family Living)
- Tag # LS27 Family Living Reimbursement

Plan of Correction:

The attached Report of Findings identifies the deficiencies found during your agency's on-site compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (Attachment A) for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

Corrective Action for Current Citation:

- How is the deficiency going to be corrected? (i.e. obtained documents, retrain staff, individuals and/or staff no longer in service, void/adjusts completed, etc.) This can be specific to each deficiency cited or if possible an overall correction, i.e. all documents will be requested and filed as appropriate.

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done on an ongoing basis? (i.e. file reviews, etc.)
- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position within your agency)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction in the available space on the two right-hand columns of the Report of Findings. *(See attachment "A" for additional guidance in completing the Plan of Correction)*.

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

1. **Quality Management Bureau, Attention: Monica Valdez, Plan of Correction Coordinator in any of the following ways:**
   a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108

2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Billing Deficiencies:
If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a "Void/Adjust" claim or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: *Lisa Medina-Lujan*
HSD/OIG/Program Integrity Unit
1474 Rodeo Road
Santa Fe, New Mexico 87505

If you have questions and would like to speak with someone at HSD/OIG/PIU, please contact:

Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)

Please be advised that there is a one-week lag period for applying payments received by check to Void/Adjust claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

Request for Informal Reconsideration of Findings (IRF):
If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

ATTN: QMB Bureau Chief
Request for Informal Reconsideration of Findings
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request/QMB

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@state.nm.us if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Kayla R. Benally, BSW

Kayla R. Benally, BSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	March 8, 2021
Contact:	**ARCA** Michelle Harmon, Clinical Services Director **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	March 8, 2021
Present:	**ARCA** Michelle Harmon, Clinical Services Director Cecile Evola, Supported Living Division Director Budd Berkman, Training Manager/Data Analyst Jennifer Madrid, FBS Support Department Manager Mahalah Stromquist, Supported Living Division Director Ensurah Ewalt, Health Service Director / Nurse Severiana Varela, Case Records Supervisor Monica Sandoval, Quality Coordinator Crucita Powell, ACES Department Manager Clarissa Garcia, Billing Specialist Sandra Taylor, Training Coordinator Melissa Wright, Human Resources Specialist 3 **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead/Healthcare Surveyor Elisa Perez Alford, MSW, Healthcare Surveyor Joshua Burghart, BS, Healthcare Surveyor Beverly Estrada, ADN, Healthcare Surveyor Lora Norby, Healthcare Surveyor Verna Newman-Sikes, AA, Healthcare Surveyor Caitlin Wall, BA, BSW, Healthcare Surveyor
Exit Conference Date:	March 19, 2021
Present:	**ARCA** Michelle Harmon, Clinical Services Director Doreen Salazar, Director of Administration Operations Cecile Evola, Supported Living Division Director Budd Berkman, Training Manager/Data Analyst Jennifer Madrid, FBS Support Department Manager Naomi Serva-Olander, Human Resources Director Dava Mantillano, Division Director ACES/IL Mahalah Stromquist, Supported Living Division Director Ensurah Ewalt, Health Service Director / Nurse Severiana Varela, Case Records Supervisor Monica Sandoval, Quality Coordinator Crucita Powell, ACES Department Manager Clarissa Garcia, Billing Specialist Sandra Taylor, Training Coordinator Melissa Wright, Human Resources Specialist 3 Christina Diaz, Supported Living Program Manager **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead/Healthcare Surveyor Elisa Perez Alford, MSW, Healthcare Surveyor

	Joshua Burghart, BS, Healthcare Surveyor Beverly Estrada, ADN, Healthcare Surveyor Lora Norby, Healthcare Surveyor Bernadette Baca, MPA, Healthcare Surveyor Caitlin Wall, BA, BSW, Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor
	DDSD - Metro Regional Office Larry Lovato, Generalist
Administrative Locations Visited:	0 *(Note: No administrative locations visited due to COVID- 19 Public Health Emergency.)*
Total Sample Size:	35
	0 - *Jackson* Class Members 35 - Non-*Jackson* Class Members
	14 - Supported Living 9 - Family Living 1 - Intensive Medical Living Supports 11 - Customized In-Home Supports 11 - Customized Community Supports 10 - Community Integrated Employment
Total Homes Observed by Video	21 *(Note: No home visits conducted due to COVID- 19 Public Health Emergency, however, Video Observations were conducted)*
❖ Supported Living Observed by Video	12 *Note: The following Individuals share a SL residence:* ➢ #2, 6 ➢ #18, 33
❖ Family Living Observed by Video	8 *Note: The following Individuals share a FL residence:* ➢ 24, 25
❖ Intensive Medical Living Observed by Video	1
Persons Served Records Reviewed	35
Persons Served Interviewed	24 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency)*
Persons Served Observed	3 (*Note: 3 individuals chose not to participate in phone/video interviews*)
Persons Served Not Seen and/or Not Available	8 *(Note: 8 Individuals were not available during the on-site survey.)*
Direct Support Personnel Records Reviewed	229 (*Note: Four DSP perform dual roles as Service Coordinators)*
Direct Support Personnel Interviewed	34 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency)*

Substitute Care/Respite Personnel Records Reviewed	17
Service Coordinator Records Reviewed	18 (*Note: Four Service Coordinators perform dual roles as DSP)*
Nurse Interview	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
    - °Individual Service Plans
    - °Progress on Identified Outcomes
    - °Healthcare Plans
    - °Medication Administration Records
    - °Medical Emergency Response Plans
    - °Therapy Evaluations and Plans
    - °Healthcare Documentation Regarding Appointments and Required Follow-Up
    - °Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
NM Attorney General's Office

Attachment A

Provider Instructions for Completing the QMB Plan of Correction (POC) Process

Introduction:
After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued deficiencies and non-compliance.

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the DDSD Regional Office for purposes of contract management or the Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings. Providers who fail to complete a POC within the 45-business days allowed will be referred to the IRC for possible actions or sanctions.

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 505-273-1930 or email at MonicaE.Valdez@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment C).

Instructions for Completing Agency POC:

Required Content
Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice cited to prevent recurrence and information that ensures the regulation cited comes into and remains in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance (QA) Plan.

If a deficiency has already been corrected since the on-site survey, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

The following details should be considered when developing your Plan of Correction:

The Plan of Correction must address each deficiency cited in the Report of Findings unless otherwise noted with a "No Plan of Correction Required statement." The Plan of Correction must address the five (5) areas listed below:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented, and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

The following details should be considered when developing your Plan of Correction:

- Details about how and when Individual Served, agency personnel and administrative and service delivery site files are audited by agency personnel to ensure they contain required documents;
- Information about how medication administration records are reviewed to verify they contain all required information before they are distributed to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (LOC) packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

Note: **Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps must be taken to ensure the deficiency is corrected and will not recur.

Completion Dates

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Monica Valdez, POC Coordinator in any of the following ways:
    a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108
5. *Do not submit supporting documentation* (evidence of compliance) to QMB *until after* your POC has been approved by the QMB.
6. QMB will notify you when your POC has been "approved" or "denied."
    a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45-business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
    b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.
    c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a *maximum* of 45-business days of receipt of your Report of Findings.

2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If documents containing HIPAA Protected Health Information (PHI) documents must be submitted through S-Comm (Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to e-mails.
3. All submitted documents *must be annotated*; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the completion date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

Attachment B

Department of Health, Division of Health Improvement
QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Assurance system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

Service Domains and CoPs for <u>Living Care Arrangements and Community Inclusion</u> are as follows:

<u>Service Domain: Service Plan: ISP Implementation -</u> *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.3 –** Administrative Case File: Individual Service Plan / ISP Components
- **1A32 –** Administrative Case File: Individual Service Plan Implementation
- **LS14 –** Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- **IS14 –** CCS / CIES Service Delivery Site Case File (ISP and Healthcare Requirements)

<u>Service Domain: Qualified Providers -</u> *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A20 -** Direct Support Personnel Training
- **1A22 -** Agency Personnel Competency
- **1A37 –** Individual Specific Training

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):

- **1A25.1 –** Caregiver Criminal History Screening
- **1A26.1 –** Consolidated On-line Registry Employee Abuse Registry

Service Domain: Health, Welfare and Safety - *The State, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.2 –** Administrative Case File: Healthcare Requirements & Follow-up
- **1A09 –** Medication Delivery Routine Medication Administration
- **1A09.1 –** Medication Delivery PRN Medication Administration
- **1A15.2 –** Administrative Case File: Healthcare Documentation (Therap and Required Plans)

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):

- **1A05 –** General Requirements / Agency Policy and Procedure Requirements
- **1A07 –** Social Security Income (SSI) Payments
- **1A09.2 –** Medication Delivery Nurse Approval for PRN Medication
- **1A15 –** Healthcare Coordination - Nurse Availability / Knowledge
- **1A31 –** Client Rights/Human Rights
- **LS25.1 –** Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

Attachment C

Guidelines for the Provider
Informal Reconsideration of Finding (IRF) Process

Introduction:
Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated "Document Request," or "Administrative Needs," etc. forms. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Bureau Chief **within 10 business days** of receipt of the final Report of Findings **(*Note: No extensions are granted for the IRF)*.**
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: https://nmhealth.org/about/dhi/cbp/irf/
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Valerie V. Valdez at valerie.valdez@state.nm.us for assistance.

The following limitations apply to the IRF process:
- The written request for an IRF and all supporting evidence must be received within 10 business days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.
- Providers may not request an IRF to challenge the DHI/QMB determination of compliance or the length of their DDSD provider contract.

A Provider forfeits the right to an IRF if the request is not received within 10 business days of receiving the report and/or does not include all supporting documentation or evidence to show compliance with the standards and regulations.

The IRF Committee will review the request; the Provider will be notified in writing of the ruling; no face-to-face meeting will be conducted.

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.

Attachment D

QMB Determinations of Compliance

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of *Compliance*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

Partial-Compliance with Standard Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags* indicates that a provider is in compliance with all Condition of Participation Level deficiencies but is out of compliance with a certain percentage of Standard Level deficiencies. This partial-compliance, if not corrected, may result in a negative outcome or the potential for more than minimal harm to individuals' health and safety. There are two ways to receive a determination of Partial Compliance with Standard Level Tags:

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.

2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety.

Non-Compliance:

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 17 or more total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level tag.

2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Total Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
COP Level Tags:	0 COP	0 COP	0 COP	0 COP	1 to 5 COP	0 to 5 CoPs	6 or more COP
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
"Non-Compliance"						**17 or more** Total Tags with **75 to 100%** of the Individuals in the sample cited in any CoP Level tag.	**Any Amount** of Standard Level Tags and **6 or more** Conditions of Participation Level Tags.
"Partial Compliance with Standard Level tags and Condition of Participation Level Tags"					**Any Amount** Standard Level Tags, plus **1 to 5** Conditions of Participation Level tags.		
"Partial Compliance with Standard Level tags"			**up to 16** Standard Level Tags with **75 to 100%** of the individuals in the sample cited in any tag.	**17 or more** Standard Level Tags with **50 to 74%** of the individuals in the sample cited any tag.			
"Compliance"	**Up to 16** Standard Level Tags with **0 to 74%** of the individuals in the sample cited in any tag.	**17 or more** Standard Level Tags with **0 to 49%** of the individuals in the sample cited in any tag.					

Agency: **ARCA - Metro**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Supported Living, Family Living, Intensive Medical Living; Customized In-Home Supports, Customized Community Supports, and Community Integrated Employment Services
Survey Type: Routine
Survey Date: **March 8 – 19, 2021**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08 Administrative Case File (Other Required Documents)	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs,	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 4 of 35 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Occupational Therapy Plan (Therapy Intervention Plan TIP):** • Not Found (#6, 10, 11) **Documentation of Guardianship/Power of Attorney:** • Not Found (#8)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. ***20.5.1 Individual Data Form (IDF):*** The Individual Data Form provides an overview of demographic information as well as other key personal, programmatic, insurance, and health related information. It lists medical information; assistive technology or adaptive equipment; diagnoses; allergies; information about whether a guardian or advance directives are in place; information about behavioral and health related needs; contacts of Provider Agencies and team members and other critical information. The IDF automatically loads information into other fields and forms and must be complete and kept current. This form is initiated by the CM. It must be opened and			

continuously updated by Living Supports, CCS- Group, ANS, CIHS and case management when applicable to the person in order for accurate data to auto populate other documents like the Health Passport and Physician Consultation Form. Although the Primary Provider Agency is ultimately responsible for keeping this form current, each provider collaborates and communicates critical information to update this form. **Chapter 3: Safeguards 3.1.2 *Team Justification Process***: DD Waiver participants may receive evaluations or reviews conducted by a variety of professionals or clinicians. These evaluations or reviews typically include recommendations or suggestions for the person/guardian or the team to consider. The team justification process includes: 1. Discussion and decisions about non-health related recommendations are documented on the Team Justification form. 2. The Team Justification form documents that the person/guardian or team has considered the recommendations and has decided: a. to implement the recommendation; b. to create an action plan and revise the ISP, if necessary; or c. not to implement the recommendation currently. 3. All DD Waiver Provider Agencies participate in information gathering, IDT meeting attendance, and accessing supplemental resources if needed and desired. 4. The CM ensures that the Team Justification Process is followed and complete.			

Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	Standard Level Deficiency		
NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY. **NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS.** **NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.** Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 6 Individual Service Plan:** The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP. ***6.5.2 ISP Revisions:*** The ISP is a dynamic document that changes with the person's desires, circumstances, and need. IDT members must collaborate and request an IDT meeting from the CM when a need to modify the ISP arises. The CM convenes the IDT within ten days of receipt of any reasonable request to convene the team, either in person or through teleconference. **6.6 DDSD ISP Template:** The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e. an acknowledgement of receipt of specific	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 35 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Addendum A**: • Not Found (#10, 11) **ISP Teaching and Support Strategies:** ***Individual #32:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • With hand over hand assistance ... will wear her glasses while in her wheelchair with 100% accuracy during her ISP year.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

information) and other elements depending on the age of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use in order to better demonstrate required elements of the PCP process and ISP development. The ISP is completed by the CM with the IDT input and must be completed according to the following requirements: 1. DD Waiver Provider Agencies should not recommend service type, frequency, and amount (except for required case management services) on an individual budget prior to the Vision Statement and Desired Outcomes being developed. 2. The person does not require IDT agreement/approval regarding his/her dreams, aspirations, and desired long-term outcomes. 3. When there is disagreement, the IDT is required to plan and resolve conflicts in a manner that promotes health, safety, and quality of life through consensus. Consensus means a state of general agreement that allows members to support the proposal, at least on a trial basis. 4. A signature page and/or documentation of participation by phone must be completed. 5. The CM must review a current Addendum A and DHI ANE letter with the person and Court appointed guardian or parents of a minor, if applicable. **6.6.3 Additional Requirements for Adults:** Because children have access to other funding sources, a larger array of services are available to adults than to children through the DD Waiver. (See Chapter 7: Available Services and Individual Budget Development). The ISP Template for adults is also more extensive, including Action Plans, Teaching			

and Support Strategies (TSS), Written Direct Support Instructions (WDSI), and Individual Specific Training (IST) requirements. **6.6.3.1. Action Plan:** Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes. Multiple service types may be included in the Action Plan under a single Desired Outcome. Multiple Provider Agencies can and should be contributing to Action Plans toward each Desired Outcome. 1. Action Plans include actions the person will take; not just actions the staff will take. 2. Action Plans delineate which activities will be completed within one year. 3. Action Plans are completed through IDT consensus during the ISP meeting. 4. Action Plans must indicate under "Responsible Party" which DSP or service provider (i.e. Family Living, CCS, etc.) are responsible for carrying out the Action Step. **6.6.3.2 Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI):** After the ISP meeting, IDT members conduct a task analysis and assessments necessary to create effective TSS and WDSI to support those Action Plans that require this extra detail. All TSS and WDSI should support the person in achieving his/her Vision. **6.6.3.3 Individual Specific Training in the ISP:** The CM, with input from each DD Waiver Provider Agency at the annual ISP meeting, completes the IST requirements section of the ISP form listing all training needs specific to the individual. Provider Agencies bring their proposed IST to the annual meeting. The IDT must reach a consensus about who needs to be trained, at what level (awareness,			

knowledge or skill), and within what timeframe. (See Chapter 17.10 Individual-Specific Training for more information about IST.) **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.			

Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and	Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 5 of 35 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #7 • None found regarding: Live Outcome/Action Step: "… with assistance will research and choose a food item to bake" for 12/2020. Action step is to be completed 1 time per month. *Note: Document maintained by the provider was blank.* Individual #10 • None found regarding: Fun Outcome/Action Step: "… will call team members" for 12/2020. Action step is to be completed 1 time per week. *Note: Document maintained by the provider was blank.* Individual #14 • None found regarding: Live Outcome/Action Step: "… with task checklist and staff assistance, will check for 7 sets of dirty underwear/socks on laundry day" for 12/2020 – 1/2021. Action step is to be completed 1 time per week.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 6: Individual Service Plan (ISP) 6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents	**Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #32 • None found regarding: Live Outcome/Action Step: "With hand over hand assistance … will wear her glasses while in her wheelchair with 100% accuracy during her ISP year" for 12/2020 – 1/2021. Action step is to be completed 2 times per week. **Customized In-Home Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #29 • None found regarding: Live Outcome/Action Step: "… will work on his recipe book with staff assistance" for 12/2020 – 1/2021. Action step is to be completed 2 times per week. • None found regarding: Live Outcome/Action Step: "… will create a calendar with staff assistance" for 12/2020 – 1/2021. Action step is to be completed 2 times per month.		

essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.			

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities.	Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 11 of 35 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #4 • According to the Live Outcome; Action Step for "… will practice using his visual schedule to complete his morning routine" is to be completed Monday - Friday. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020 – 1/2021. • According to the Health Outcome; Action Step for "… will order strips and glucose tabs and ask staff to confirm order" is to be completed monthly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020. Individual #6 • According to the Live Outcome; Action Step for "… will assist with preparing a meal" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 6: Individual Service Plan (ISP) 6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:	Individual #8 • According to the Live Outcome; Action Step for "… will research different places he would like to vacation" is to be completed 2 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020 – 1/2021. Individual #10 • According to the Fun Outcome; Action Step for "… will call team members" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2021. Individual #14 • According to the Live Outcome; Action Step for "… with task checklist and verbal reminders from staff, will place his dirty underwear and socks on a daily basis in the laundry basket" is to be completed daily. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020 – 1/2021. Individual #18 • According to the Live Outcome; Action Step for "with staff verbal prompting and HOH, … will mix up a cool aide in a" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020 – 1/2021. • According to the Live Outcome; Action Step for "With staff prompting, … will pour the drink into his glass" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required		

8. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 9. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 11. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 12. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 13. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 14. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.	frequency as indicated in the ISP for 12/2020 – 1/2021. **Family Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes:** Individual #34 • According to the Live Outcome; Action Step for "Review available options" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2021. • According to the Live Outcome; Action Step for "Practice expressing his choice" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2021. **Intensive Medical Living Data Collection/Data Tracking / Progress with regards to ISP Outcomes**: Individual #28 • According to the Live Outcome; Action Step for "… with staff assistance, will open the medication packet" is to be completed daily. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020 – 1/2021. • According to the Live Outcome; Action Step for "… with staff assistance, will be able to identify her medications in the packet with pictures of her medications" is to be completed daily. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020 – 1/2021.		

	• According to the Health Outcome; Action Step for "… will set an alarm on her iPad to stand" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020 – 1/2021. • According to the Health Outcome; Action Step for "… will complete a functional activity after she stands" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020 – 1/2021. **Customized In-Home Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #19 • According to the Live Outcome; Action Step for "… will choose a healthy recipe to prepare with staff assistance" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020 – 1/2021. • According to the Live Outcome; Action Step for "… will prepare his meal using visual prompts with staff assistance" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020 – 1/2021. Individual #35 • According to the Live Outcome; Action Step for "… will meet with his ARCA DSP or caseworker to review finances" is to be completed 1 time per week. Evidence found		

	indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • According to the Fun Outcome; Action Step for "… and CCS – I staff will create a weekly schedule using a calendar" is to be completed weekly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2020. Individual #8 • According to the Work Outcome; Action Step for "… will research new activities utilizing Internet, newspaper, etc." is to be completed 4 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2021.		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A22 Agency Personnel Competency	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 13: Nursing Services *13.2.11 Training and Implementation of Plans:*** 1. RNs and LPNs are required to provide Individual Specific Training (IST) regarding HCPs and MERPs. 2. The agency nurse is required to deliver and document training for DSP/DSS regarding the healthcare interventions/strategies and MERPs that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee as described in Chapter 17.10 Individual-Specific Training. **Chapter 17: Training Requirement** **17.10 Individual-Specific Training:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan	Based on interview, the Agency did not ensure training competencies were met for 4 of 34 Direct Support Personnel. **When DSP were asked, if the Individual had a Positive Behavioral Supports Plan (PBSP), have you been trained on the PBSP and what does the plan cover, the following was reported:** • DSP #606 stated, "Yes, to work with him on being more comfortable out in the community." According to the Individual Specific Training Section of the ISP the Individual does not require a Positive Behavioral Supports Plan. (Individual #2) • DSP #558 stated, "He does, he has a tendency to sulk if he doesn't get his way. He has PTSD and we try and offer him choices, we listen and encourage him." According to the Individual Specific Training Section of the ISP the Individual does not require a Positive Behavioral Supports Plan. (Individual #2) **When DSP were asked, if they received training on the Individual's Behavioral Crisis Intervention Plan (BCIP) and if so, what the plan covered, the following was reported:** • DSP #606 stated, "Yes, he becomes quiet. If so sit with him and listen to him." According to the Individual Specific Training Section of the ISP, the individual does not	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported. 1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends. 2. IST for therapy-related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher. 3. The competency level of the training is based on the IST section of the ISP. 4. The person should be present for and involved in IST whenever possible.	require a Behavioral Crisis Intervention Plan. (Individual #2) • DSP #742 stated, "No, he does not." According to the Individual Specific Training Section of the ISP, the individual requires a Behavioral Crisis Intervention Plan. (Individual #8) **When DSP were asked, if the Individual's had Medical Emergency Response Plans and where could they be located, the following was reported, the following was reported:** • DSP #742 stated, "Seizure Disorders, she also has Injury/Falls, I missed that one." As indicated the Individual Specific Training section of the ISP the Individual additionally requires Medical Emergency Response Plans for: Gastrointestinal – Constipation (Impaction), Electrolyte Imbalance, and MRSA. (Individual #27) • DSP #548 stated, "Seizure Disorders, Injury, Falls, Pain" As indicated by the Individual Specific Training section of the ISP the Individual additionally requires Medical Emergency Response Plans for: Gastrointestinal – Constipation (Impaction), Electrolyte Imbalance, and MRSA. (Individual #27) **When DSP were asked, if the Individual had any food and / or medication allergies that could be potentially life threatening, the following was reported:** • DSP #742 stated, "None are listed on her ISP." As indicated by the Electronic Comprehensive Health Assessment Tool		

5. Provider Agencies are responsible for tracking of IST requirements. 6. Provider Agencies must arrange and ensure that DSP's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings. 7. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan.	the individual is allergic to Diuretic Tablets. (Individual #27) • DSP #548 stated, "The only allergies listed is Hay Fever, on her MAR it says no known drug allergies." As indicated by the Electronic Comprehensive Health Assessment Tool the individual is allergic to Diuretic Tablets. (Individual #27)		

Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	Standard Level Deficiency		
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 3 of 260 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Personnel (DSP):** • #511 – Date of hire 7/24/2019, completed 7/25/2019. • #540 – Date of hire 9/11/2019, completed 9/12/2019. • #638 – Date of hire 10/1/2019, completed 10/2/2019.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

appropriate identifying information required by the registry. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.			

Tag # 1A43.1 General Events Reporting: Individual Reporting	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 19: Provider Reporting Requirements: 19.2 General Events Reporting (GER):** The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows: 1. DD Waiver Provider Agencies approved to provide Customized In-Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use GER in the Therap system. 2. DD Waiver Provider Agencies referenced above are responsible for entering specified information into the GER section of the secure website operated under contract by Therap according to the GER Reporting Requirements in Appendix B GER Requirements. 3. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap. 4. GER does not replace a Provider Agency's obligations to report ANE or other	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 7 of 35 individuals. **The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within the required timeframe:** **Individual #15** • General Events Report (GER) indicates on 5/19/2020 the Individual stated during a phone call he would kill himself. (Suicide). GER was approved 5/22/2020. **Individual #26** • General Events Report (GER) indicates on 10/1/2020 FLP forgot to sign MAR for an allergy medication. (Medication Error). GER was approved 11/30/2020. • General Events Report (GER) indicates on 1/26/2021 Individual injured fingers during a seizure. (Injury). GER was approved 2/1/2021. **Individual #27** • General Events Report (GER) indicates on 4/13/2020 Individual fell when getting up from a chair. (Fall without Injury). GER was approved 4/16/2020. • General Events Report (GER) indicates on 4/17/2020 Individual fell when answering the door. (Fall without Injury). GER was approved 4/22/2020.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

reportable incidents as described in Chapter 18: Incident Management System. 5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities. **Appendix B GER Requirements:** DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting: 1. *Effective immediately*, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau. 2. No alternative methods for reporting are permitted. **The following events need to be reported in the Therap GER:** • Emergency Room/Urgent Care/Emergency Medical Services • Falls Without Injury • Injury (including Falls, Choking, Skin Breakdown and Infection) • Law Enforcement Use • Medication Errors • Medication Documentation Errors • Missing Person/Elopement • Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission • PRN Psychotropic Medication • Restraint Related to Behavior • Suicide Attempt or Threat **Entry Guidance:** Provider Agencies must complete the following sections of the GER with detailed information: profile information, event information, other event information,	• General Events Report (GER) indicates on 9/11/2020 there was a medication error. (Medication Error). GER was approved on 10/15/2020. **Individual #30** • General Events Report (GER) indicates on 4/4/2020 the Individual injured himself getting into van. (Injury). GER was approved 4/8/2020. **The following events were not reported in the General Events Reporting System as required by policy:** **Individual #1** • Documentation reviewed indicates on 7/31/2020 the Individual was assessed at Urgent Care for a medication error (Urgent Care). No GER was found. **Individual #8** • Documentation reviewed indicates on 11/6/2020 the Individual was not provided a medication (Medication Error). No GER was found. **Individual #23** • Documentation reviewed indicates on 4/28/2020 the Individual was assessed at Urgent Care for swelling of the left eye (Urgent Care). No GER was found.		

general information, notification, actions taken or planned, and the review follow up comments section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 3 Safeguards: 3.1.1 *Decision Consultation Process (DCP):*** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: 1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such	Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 4 of 35 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):*** **Coumadin:** • Individual #28 - As indicated by collateral documentation reviewed, Coumadin visit was completed on 12/28/2020. Follow-up was to be completed on 2/1/2021. No evidence of follow-up found. **Dental Exam:** • Individual #5 - As indicated by collateral documentation reviewed, exam was completed on 1/29/2021. Exam was not linked / attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* • Individual #7 - As indicated by collateral documentation reviewed, exam was completed on 2/24/2021. Follow-up was to be completed on 3/4/2021. No evidence of follow-up found.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

as the Individual Quality Review (IQR) or other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain	**Primary Care:** • Individual #16 - As indicated by collateral documentation reviewed, exam was completed on 12/31/2020. Follow-up was to be completed. Exam was not linked / attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)*		

individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.			

7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 *Health Passport and Physician Consultation Form:*** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. **Chapter 10: Living Care Arrangements (LCA) Living Supports-Supported Living: 10.3.9.6.1 Monitoring and Supervision** 4. Ensure and document the following: a. The person has a Primary Care Practitioner. b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist. c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist. d. The person receives a hearing test as recommended by a licensed audiologist. e. The person receives eye examinations as			

recommended by a licensed optometrist or ophthalmologist. 5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine). **10.3.10.1 Living Care Arrangements (LCA) Living Supports-IMLS: 10.3.10.2 General Requirements:** 9 . Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and annual dental checkup by a licensed dentist). **Chapter 13 Nursing Services: 13.2.3 General Requirements:** 1. Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information.			

Tag # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the month of February 2021. Based on record review, 4 of 19 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #2 February 2021 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Aripiprazole 5 mg (1 time daily) – Blank 2/28 (7:00 PM) • Clemastine Fumarate 2.68 mg, ½ tablet (1 time daily) – Blank 2/28 (5:00 PM) • Clinpro 5000 1.1 paste (1 time daily) – Blank 2/28 (7:00 PM) • Lithium Carbonate 300 mg (2 times daily) – Blank 2/28 (7:00 PM) Individual #4 February 2021 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Adderall 5 mg, ½ tablet, 14 days (1 time daily) – Blank 2/23, 25 (8:00 AM)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training;	• Lotrimin AF 2% Aero Powder (2 times daily) – Blank 2/2 (8:00 AM) Individual #18 During on-site survey Medication Administration Records were requested for month of February 2021. As of 3/19/2021, Medication Administration Records for February had not been provided. Individual #26 February 2021 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Polyethylene Glycol 3350.17 gram/dose, 9 grams in 8 oz water (1 time daily) – Blank 2/1 - 28. As indicated by the Medication Administration Records the individual is to take Alendronate Sodium 70 mg 1 tablet. According to the Physician's Orders, Alendronate Sodium 70 mg 1 tablet is to be taken 1 time every 7 days. Medication Administration Record and Physician's Orders do not match. Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Lactose Reduced Food Fiber 0.06 gram 1.5K Cal/ml Liquid, One box 180 ml (3 times daily) • Polyethylene Glycol 3350.17 gram/dose, 9 grams in 8 oz water (1 time daily) • Probiotic Acidophilus with Pectin Caps (2 times daily)		

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR). **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the			

administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24-hour period.			

Tag # 1A09.0 Medication Delivery Routine Medication Administration	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 8. Including the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the	Medication Administration Records (MAR) were reviewed for the months of February 2021 Based on record review, 4 of 19 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #25 February 2021 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Divalproex Sodium 125 mg, 4 tabs (1 time daily) • Divalproex Sodium 125 mg, 5 tabs (1 time daily) Individual #26 February 2021 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Alendronate Sodium 70 mg (1 time daily) • Montelukast Sodium (1 time daily) • Topiramate 50 mg (1 time daily) • Topiramate 50 mg (1 time daily) Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications:	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training;	• Polyethylene Glycol 3350.17 gram/dose, 9 grams in 8 oz water (1 time daily) Individual #27 February 2021 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Calcium Citrate – Vitamin D3 315-250 mg unit (1 time daily) • Levothyroxine Sodium 25 mcg (1 time daily) Individual #28 February 2021 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Warfarin Sodium 3 mg (every Monday)		

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR). **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the			

administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24-hour period.			

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the month of February 2021. Based on record review, 6 of 19 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #7 February 2021 As indicated by the Medication Administration Records the individual is to take Acetaminophen 600 mg (PRN). According to the Physician's Orders, Acetaminophen 500 mg is to be taken as needed. Medication Administration Record and Physician's Orders do not match. Individual #8 February 2021 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Ibuprofen 200 mg (PRN) Individual #14 February 2021 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 200 mg, Dose 400 mg – PRN – 2/18 (given 1 time) Individual #18	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training;	During on-site survey Medication Administration Records were requested for month of February 2021. As of 3/19/2021, Medication Administration Records for February had not been provided. Individual #25 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Mucinex 600 mg ER 12 H (PRN) • Ventolin HFA 90 mcg/actuation HFA AER (PRN) Individual #27 February 2021 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Milk of Magnesia 30 ml – PRN – 2/20 (given 1 time)		

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).			

Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the	Medication Administration Records (MAR) were reviewed for the month of February 2021 Based on record review, 1 of 19 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #25 February 2021 Medication Administration Records did not contain the circumstance for which the medication is to be used: • Ventolin HFA 90 mcg/actuation HFA AER Generic (Albuterol Sulfate) (PRN) • Nystatin 100,000 unit/gram (PRN)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training;			

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).			

Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 13 Nursing Services: *13.2.12 Medication Delivery:*** Nurses are required to: 1. Be aware of the New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations. 2. Communicate with the Primary Care Practitioner and relevant specialists regarding medications and any concerns with medications or side effects. 3. Educate the person, guardian, family, and IDT regarding the use and implications of medications as needed. 4. Administer medications when required, such as intravenous medications; other specific injections; via NG tube; non-premixed nebulizer treatments or new prescriptions that have an ordered assessment. 5. Monitor the MAR or treatment records at least monthly for accuracy, PRN use and errors. 6. Respond to calls requesting delivery of PRNs from AWMD trained DSP and non-related (surrogate or host) Family Living Provider Agencies. 7. Assure that orders for PRN medications or treatments have: a. clear instructions for use; b. observable signs/symptoms or circumstances in which the medication is to be used or withheld; and c. documentation of the response to and effectiveness of the PRN medication administered. 8. Monitor the person's response to the use of routine or PRN pain medication and contact the prescriber as needed regarding its effectiveness. 9. Assure clear documentation when PRN	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation of PRN authorization as required by standard for 4 of 19 Individuals. Individual #6 February 2021 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Acetaminophen 500 mg – PRN – 2/28 (given 1 time) Individual #10 February 2021 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Acetaminophen 1000 mg – PRN – 2/18 (given 1 time) Individual #14 February 2021 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Ibuprofen 200 mg (Dose 400 mg) – PRN – 2/18 (given 1 time) Individual #27 February 2021	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

medications are used, to include: a. DSP contact with nurse prior to assisting with medication. i. The only exception to prior consultation with the agency nurse is to administer selected emergency medications as listed on the Publications section of the DOH-DDSD -Clinical Services Website https://nmhealth.org/about/ddsd/pgsv/clinical/. b. Nursing instructions for use of the medication. c. Nursing follow-up on the results of the PRN use. d. When the nurse administers the PRN medication, the reasons why the medications were given and the person's response to the medication.	No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Acetaminophen 500 mg – PRN – 2/19 (given 1 time)		

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 22 of 35 individual Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Comprehensive Aspiration Risk Management Plan*:*** • Not linked/attached in Therap (#4, 7) *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* **Healthcare Passport:** ➢ Did not contain Name of Physician (#33) ➢ Did not contain Emergency Contact Information (#8, 10, 11, 12, 13, 15, 17, 18, 19, 20, 25, 28, 30, 31, 33, 35) ➢ Did not contain Information regarding Allergies (#33) ➢ Did not contain Guardianship/Healthcare Decision Maker (#6, 7, 8, 16, 18, 25, 28, 31, 33) **Health Care Plans:** ***Constipation Management:*** • Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **Chapter 3 Safeguards: 3.1.1 *Decision Consultation Process (DCP):*** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: 2. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;	Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Dental Hygiene:*** • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Diabetes Type I:*** • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Falls:*** • Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* • Individual #19 - As indicated by the IST section of ISP the individual is required to have a plan. Evidence indicated the plan was not current. ***Seizure Disorder:*** • Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked*		

b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.	*/ attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Status of Care/Hygiene:*** • Individual #28 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. **Medical Emergency Response Plans:** ***Airway Obstruction Respiratory Distress:*** • Individual #26 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Allergies:*** • Individual #26 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Anaphylactic:*** • Individual #26 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Aspiration Risk:*** • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* • Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)*		

Chapter 13 Nursing Services: ***13.2.5 Electronic Nursing Assessment and Planning Process:*** The nursing assessment process includes several DDSD mandated tools: the electronic Comprehensive Nursing Assessment Tool (e-CHAT), the Aspiration Risk Screening Tool (ARST) and the Medication Administration Assessment Tool (MAAT). This process includes developing and training Health Care Plans and Medical Emergency Response Plans. The following hierarchy is based on budgeted services and is used to identify which Provider Agency nurse has primary responsibility for completion of the nursing assessment process and related subsequent planning and training. Additional communication and collaboration for planning specific to CCS or CIE services may be needed. The hierarchy for Nursing Assessment and Planning responsibilities is: 1. Living Supports: Supported Living, IMLS or Family Living via ANS; 2. Customized Community Supports- Group; and 3. Adult Nursing Services (ANS): a. for persons in Community Inclusion with health-related needs; or b. if no residential services are budgeted but assessment is desired and health needs may exist. ***13.2.6 The Electronic Comprehensive Health Assessment Tool (e-CHAT)*** 1. The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person. 2. The nurse must see the person face-to-face to complete the nursing assessment. Additional information may be gathered from members of the IDT and other sources. 3. An e-CHAT is required for persons in FL,	• Individual #18 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Cardiac Condition:*** • Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Diabetes Type I:*** • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Falls:*** • Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* • Individual #18 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • Individual #26 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Hypertension:*** • Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Potential for Infection:***		

SL, IMLS, or CCS-Group. All other DD Waiver recipients may obtain an e-CHAT if needed or desired by adding ANS hours for assessment and consultation to their budget. 4. When completing the e-CHAT, the nurse is required to review and update the electronic record and consider the diagnoses, medications, treatments, and overall status of the person. Discussion with others may be needed to obtain critical information. 5. The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections. ***13.2.7 Aspiration Risk Management Screening Tool (ARST)*** ***13.2.8 Medication Administration Assessment Tool (MAAT):*** 1. A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting. 2. After completion of the MAAT, the nurse will present recommendations regarding the level of assistance with medication delivery (AWMD) to the IDT. A copy of the MAAT will be sent to all the team members two weeks before the annual ISP meeting and the original MAAT will be retained in the Provider Agency records. 3. Decisions about medication delivery are made by the IDT to promote a person's maximum independence and community integration. The IDT will reach consensus regarding which criteria the person meets, as indicated by the results of the MAAT and the nursing recommendations, and the decision is documented this in the ISP. **13.2.9 Healthcare Plans (HCP)*:***	• Individual #14 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Seizure Disorder:*** • Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)*		

1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. 2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs plans that the nurse determines are warranted. ***13.2.10 Medical Emergency Response Plan (MERP):*** 1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP. 2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.			

Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and Physician Consultation Form: All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form.			

Tag # 1A31 Client Rights / Human Rights	Condition of Participation Level Deficiency		
NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not ensure the rights of Individuals was not restricted or limited for 5 of 35 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. <u>No documentation</u> was found regarding Human Rights Approval for the following: • Arm's Length Distance. No evidence found of Human Rights Committee approval. (Individual #8, 14) • Law Enforcement and / or CIT. No evidence found of Human Rights Committee approval. (Individual #4, 14, 28) • Line of Sight. No evidence found of Human Rights Committee approval. (Individual #14) • Money Management. No evidence found of Human Rights Committee approval. (Individual #6) • Physical Restraint (Agency Approved) – No evidence found of Human Rights Committee approval. (Individual #14)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Chapter 2: Human Rights: Civil rights apply to everyone, including all waiver participants, family members, guardians, natural supports, and Provider Agencies. Everyone has a responsibility to make sure those rights are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to best support the person. **Chapter 3 Safeguards: *3.3.1 HRC Procedural Requirements:*** 1. An invitation to participate in the HRC meeting of a rights restriction review will be given to the person (regardless of verbal or cognitive ability), his/her guardian, and/or a family member (if desired by the person), and the Behavior Support Consultant (BSC) at least 10 working days prior to the meeting (except for in emergency situations). If the person (and/or the guardian) does not wish to attend, his/her stated preferences may be brought to the meeting by someone whom the person chooses as his/her representative. 2. The Provider Agencies that are seeking to temporarily limit the person's right(s) (e.g., Living Supports, Community Inclusion, or BSC) are required to support the person's informed consent regarding the rights restriction, as well as their timely participation in the review. 3. The plan's author, designated staff (e.g., agency service coordinator) and/or the CM makes a written or oral presentation to the HRC. 4. The results of the HRC review are reported in writing to the person supported, the guardian, the BSC, the mental health or other specialized therapy provider, and the CM within three working days of the meeting. 5. HRC committees are required to meet at least on a quarterly basis. 6. A quorum to conduct an HRC meeting is at			

least three voting members eligible to vote in each situation and at least one must be a community member at large. 7. HRC members who are directly involved in the services provided to the person must excuse themselves from voting in that situation. Each HRC is required to have a provision for emergency approval of rights restrictions based upon credible threats of harm against self or others that may arise between scheduled HRC meetings (e.g., locking up sharp knives after a serious attempt to injure self or others or a disclosure, with a credible plan, to seriously injure or kill someone). The confidential and HIPAA compliant emergency meeting may be via telephone, video or conference call, or secure email. Procedures may include an initial emergency phone meeting, and a subsequent follow-up emergency meeting in complex and/or ongoing situations. 8. The HRC with primary responsibility for implementation of the rights restriction will record all meeting minutes on an individual basis, i.e., each meeting discussion for an individual will be recorded separately, and minutes of all meetings will be retained at the agency for at least six years from the final date of continuance of the restriction. ***3.3.3 HRC and Behavioral Support:*** The HRC reviews temporary restrictions of rights that are related to medical issues or health and safety considerations such as decreased mobility (e.g., the use of bed rails due to risk of falling during the night while getting out of bed). However, other temporary restrictions may be implemented because of health and safety considerations arising from behavioral issues. Positive Behavioral Supports (PBS) are mandated and used when behavioral support			

is needed and desired by the person and/or the IDT. PBS emphasizes the acquisition and maintenance of positive skills (e.g. building healthy relationships) to increase the person's quality of life understanding that a natural reduction in other challenging behaviors will follow. At times, aversive interventions may be temporarily included as a part of a person's behavioral support (usually in the BCIP), and therefore, need to be reviewed prior to implementation as well as periodically while the restrictive intervention is in place. PBSPs not containing aversive interventions do not require HRC review or approval. Plans (e.g., ISPs, PBSPs, BCIPs PPMPs, and/or RMPs) that contain any aversive interventions are submitted to the HRC in advance of a meeting, except in emergency situations. **3.3.4 Interventions Requiring HRC Review and Approval:** HRCs must review prior to implementation, any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies, including but not limited to: 1. response cost; 2. restitution; 3. emergency physical restraint (EPR); 4. routine use of law enforcement as part of a BCIP; 5. routine use of emergency hospitalization procedures as part of a BCIP; 6. use of point systems; 7. use of intense, highly structured, and specialized treatment strategies, including level systems with response cost or failure to earn components; 8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons; 9. use of PRN psychotropic medications; 10. use of protective devices for behavioral			

purposes (e.g., helmets for head banging, Posey gloves for biting hand); 11. use of bed rails; 12. use of a device and/or monitoring system through PST may impact the person's privacy or other rights; or 13. use of any alarms to alert staff to a person's whereabouts. **3.4 Emergency Physical Restraint (EPR):** Every person shall be free from the use of restrictive physical crisis intervention measures that are unnecessary. Provider Agencies who support people who may occasionally need intervention such as Emergency Physical Restraint (EPR) are required to institute procedures to maximize safety. ***3.4.5 Human Rights Committee:*** The HRC reviews use of EPR. The BCIP may not be implemented without HRC review and approval whenever EPR or other restrictive measure(s) are included. Provider Agencies with an HRC are required to ensure that the HRCs: 1. participate in training regarding required constitution and oversight activities for HRCs; 2. review any BCIP, that include the use of EPR; 3. occur at least annually, occur in any quarter where EPR is used, and occur whenever any change to the BCIP is considered; 4. maintain HRC minutes approving or disallowing the use of EPR as written in a BCIP; and 5. maintain HRC minutes of meetings reviewing the implementation of the BCIP when EPR is used.			

Tag # LS06 Family Living Requirements	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 10: Living Care Arrangements (LCA)** ***10.3.8 Living Supports Family Living: 10.3.8.2 Family Living Agency Requirement*** ***10.3.8.2.1 Monitoring and Supervision:*** Family Living Provider Agencies must: 1. Provide and document monthly face-to-face consultation in the Family Living home conducted by agency supervisors or internal service coordinators with the DSP and the person receiving services to include: a. reviewing implementation of the person's ISP, Outcomes, Action Plans, and associated support plans, including HCPs, MERPs, PBSP, CARMP, WDSI; b. scheduling of activities and appointments and advising the DSP regarding expectations and next steps, including the need for IST or retraining from a nurse, nutritionist, therapists or BSC; and c. assisting with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator, or other IDT members. 2. Monitor that the DSP implement and document progress of the AT inventory, physician and nurse practitioner orders, therapy, HCPs, PBSP, BCIP, PPMP, RMP, MERPs, and CARMPs. **10.3.8.2.2 Home Studies:** Family Living Provider Agencies must complete all DDSD requirements for an approved home study prior to placement. After the initial home study, an updated home study must be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used	Based on record review, the Agency did not complete all DDSD requirements for approval of each direct support provider for 3 of 9 individuals. Review of the Agency files revealed the following items were not found, incomplete, and/or not current: **Components of Monthly Consultation:** • Individual #25 – Components Not Found: Health Care Plans and Medical Emergency Response Plans. • Individual #26 – Components Not Found: Health Care Plans and Medical Emergency Response Plans. • Individual #34 – Components Not Found: Health Care Plans and Medical Emergency Response Plans.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

by the Provider Agency to conduct home studies must be approved by DDSD and must comply with CMS settings requirements.			

Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 10: Living Care Arrangements (LCA) 10.3.6 Requirements for Each Residence:** Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence: 1. has basic utilities, i.e., gas, power, water, and telephone; 2. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher; 3. has a general-purpose first aid kit; 4. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift; 5. has water temperature that does not exceed a safe temperature (110^0 F); 6. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP; 7. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy; 8. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 9. supports environmental modifications and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 2 of 20 Living Care Arrangement residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Poison Control Phone Number (#2, 6) *Note: The following Individuals share a residence:* ➢ #2, 6 ➢ #18, 33 **Family Living Requirements:** • Carbon monoxide detectors (#34) *Note: The following Individuals share a residence:* ➢ #24, 25	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

toilets, etc.) based on the unique needs of the individual in consultation with the IDT; 10. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed; 11. has the phone number for poison control within line of site of the telephone; 12. has general household appliances, and kitchen and dining utensils; 13. has proper food storage and cleaning supplies; 14. has adequate food for three meals a day and individual preferences; and 15. has at least two bathrooms for residences with more than two residents.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag # LS27 Family Living Reimbursement	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and h. the nature of services. 3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer. 4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Family Living Services for 1 of 9 individuals. Individual #32 January 2021 • The Agency billed 1 unit of Family Living (T2033 HB) on 1/8/2021. Documentation did not contain the required element on 1/8/2021. Documentation received accounted for 0 units. The required element was not met: ➢ Start and end time of each service encounter or other billable service interval • The Agency billed 1 unit of Family Living (T2033 HB) on 1/29/2021. Documentation did not contain the required element on 1/29/2021. Documentation received accounted for 0 units. The required element was not met: ➢ Start and end time of each service encounter or other billable service interval	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

of the following for a period of at least six years from the payment date: a. treatment or care of any eligible recipient; b. services or goods provided to any eligible recipient; c. amounts paid by MAD on behalf of any eligible recipient; and d. any records required by MAD for the administration of Medicaid. **21.9 Billable Units:** The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: 1. A day is considered 24 hours from midnight to midnight. 2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period. 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. 4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows: a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%). b. The receiving Provider Agency bills the remaining days up to 340 for the ISP year.			

21.9.2 Requirements for Monthly Units: For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days. 2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. 4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit. **21.9.3 Requirements for 15-minute and hourly units**: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following: 1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2. 2. Services that last in their entirety less than eight minutes cannot be billed.			

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DR. TRACIE C. COLLINS, M.D.
Cabinet Secretary

Date:	July 8, 2021
To:	Michelle Harmon, Clinical Services Director
Provider:	ARCA
Address:	11300 Lomas Blvd. NE
State/Zip:	Albuquerque, New Mexico 87112-5512
E-mail Address:	mharmon@arcaspirit.org
Region:	Metro
Survey Date:	March 8 – 19, 2021
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Family Living, Intensive Medical Living, Customized In-Home Supports, Customized Community Supports, and Community Integrated Employment Services
Survey Type:	Routine

Dear Ms. Harmon:

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete.

Furthermore, your agency is now determined to be in Compliance with all Conditions of Participation.

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

Consistent use of these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Monica Valdez, BS

Monica Valdez, BS
Healthcare Surveyor Advanced/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.21.3.DDW.D0085.5.RTN.09.21.189